Problems that patients feel are appropriate to discuss with their GPs

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Summary

A descriptive study was performed to discover what problems patients felt it appropriate to discuss with their general practitioner, their use of alternative therapies, and any questions they wished their doctor had asked them in the past. Demographic data was recorded including Church attendance.

Data was collected using an original questionnaire distributed to two groups of patients; 150 consecutive patients attending the surgery (surgery group) and 220 randomly selected from the adult age-sex register (home group). Chi-squared analysis was performed.

A broad range of subjects appropriate to a general practice consultation was found (from influenza to spiritual problems). Prior use of homeopathy and hypnosis was widespread. Multiple attenders were more likely to be church attenders. Men in the surgery group were most likely to discuss marital, relationship and spiritual problems.

Qualitative data from open questions demonstrated patients' concerns with consultation time and the exploration of feelings.

Introduction

The consultation lies at the heart of general practice; its boundaries are without limits. While the patient may bring physical symptoms, severe or otherwise, they may also bring those problems formerly the province of a spouse, friend, parent or priest. The protean nature of the consultation is part of the appeal of general practice. However it relies for its fulfilment upon certain conditions; time, trust, a patient-centredness, and what Neighbour[1] has termed 'nowness'; an ability on the part of the doctor to concentrate on the matter in hand and to be fulfilled by the consultation.

It seems ironic therefore that while GPs have been exploring the mysteries of the consultation, a number of changes have been wrought upon them which vie for their attention. Time becomes an issue; time for the consultation, for the presenting complaint, time for screening, time for health-checks, over 75s visiting and health promotion, time for paperwork and computers. Many authors have pointed to the increased satisfaction amongst patients when they are given time[2-10], and it has been shown that while consulting for longer periods doctors are more likely to advise on prevention and give more information[3,4]. They are also less likely to prescribe[3,4].

Recent changes provide financial incentives to encourage GPs to increase their list sizes, therefore reducing time with individual patients[8], to indulge in the disease-centredness of screening and health promotion clinics for previously low-attenders (with the attendant anxiety generated)[11], and to undertake more of their own night visits (although fatigue leads to impairment of empathy)[12].

Thus while it has been argued elsewhere that it is the caring in hospital medicine which has been threatened by reductionism's 'cure'[13], the premise of general practice now also seems to have shifted towards quantity (targets and those data which are measurable) away from quality.

What problems should patients bring to their GPs? Obviously there is no strictly correct answer. Those who attend at all are likely to be different to those who do not. Three out of four episodes of illness in the community are self-treated, 85% of those attending will have sought advice elsewhere before coming[14-16] and 9% of all consultations outside hospitals in the UK are with practitioners of complementary medicine[17].

Those who attend repeatedly, and in the doctor's opinion inappropriately, form a much studied subgroup[18-26]. So-called 'heartsink' patients, frequent attenders, and those their doctors simply don't like, form a heterogeneous group with certain features in common, high pre-disposition to neurotic illness[18,23], high prevalence of affective neurosis[18,23], chronic physical illness and marital breakdown[18,21,22], the presence of disturbed individuals within their families[19], unemployment in men, and loneliness in women[20], a greater number of symptoms than controls[26], fewer symptom-free days[26], poorer coping strategies[26], less rich social lives and a higher chance of being single[26]. They undoubtedly form a large proportion of that seventh of patients who account for almost half of all doctor-patient contacts[22]. Time may be all a doctor can give to these patients before they move on as they tend to[21,27,28].

Many patients seem to be moving on to complementary or alternative therapies. Why is this so? Hill suggests that this is part of a wider change of perspective related to the questions of ecology and the environment and that patients are looking for an interpretation of their predicament in wider terms, away from the reductionism of orthodox medicine[17]. Self-help and lay-help groups have also increased calling into question our emphasis upon the consultation between individuals and representing for Pietroni, 'a reflection of the need for a communal or group experience similar to the healing ceremonies found in more primitive cultures'[16].

The purpose of the present study was to assess in some preliminary way those problems that patients felt it appropriate to discuss with their doctors. Allied to this was a concern to discover how many of the patients were using or had used some form of alternative therapy, whether this was related to multiple attendances in the previous year, and whether demographic details such as age, sex, marital status and church attendance had any bearing. The method chosen was that of an original questionnaire.

The practice where the study took place is a training group practice of seven partners (five male and two female) which had two trainees at the time of the study. It is located in a purpose-built health centre in an outer London suburb. There are approximately 14 000 patients with an average attendance rate of 3.4 consultations per year. The patients were predominantly middle class, social class II, III and IV. The practice has a larger than average list of over 65-year-olds (18%).

Methods

The methodology was that of a descriptive study with data collected by questionnaire. In order to study those issues patients felt that they should be able to discuss with their GP, a questionnaire was devised as shown in Table 1. Patients were asked whether they felt the following were appropriate topics to discuss with their GP; 'the flu' (influenza), headaches, stress, giving-up smoking, housing problems, marital problems, sexual difficulties, family/relationship difficulties and spiritual problems. Similar questions were asked regarding whether patients had used any alternative therapies, whether there were any problems they would not wish to discuss with their GP, whether there had ever been a question that they wished their GP had asked but which he/she did not, and an estimate of their frequency of attendance in the previous year. Other demographic data were included on the questionnaire; sex, marital status, age group, and attendance at church, synagogue or mosque. The questionnaire was anonymous and unmarked.

Table 1. Questionnaire

(1) Do you think the following are appropriate topics to discuss with your GP?
- (a) The flu (influenza)
- (b) Headaches
- (c) Stress
- (d) Giving up smoking
- (e) Housing problems
- (f) Marital problems
- (g) Sexual difficulties
- (h) Family/relationship difficulties
- (i) Spiritual problems

(2) Have you ever tried any of the following therapies?
- (a) Hypnosis
- (b) Osteopathy
- (c) Acupuncture
- (d) Herbalism
- (e) Homeopathy
- (f) Other (please specify)

(3) If you answered 'Yes' to any of the last questions, did you . . .
- (a) Try this therapy *rather* than ordinary medicine
- (b) Use it where ordinary medicine had *failed*
- (c) Use it *with* ordinary medicine

(4) Are there any questions you would *not* wish to discuss with your GP? If so please specify . . .

(5) Has there ever been a question that you wished your GP had asked but which he/she didn't?

(6) In the past year have you consulted your GP
- (a) Once or less
- (b) More than once but less than five times
- (c) Five or more times

(7) Are you
- Male
- Female

(8) Are you
- Single
- Married/living with partner
- Divorced/separated
- Widowed

(9) Age
- Under 25
- 25-40
- 41-60
- Over 60

(10) Do you attend a church, synagogue or mosque?

Early in December 1990, 150 questionnaires were distributed to consecutive patients attending the health centre to be completed while in the waiting room. Completed questionnaires were returned to the collection box. The patients attending had appointments with any of the seven partners, two trainees or practice nurse. All the questionnaires were returned, 17 incorrectly completed, and 133 correctly completed. The responses were labelled 'surgery group'.

In January 1991 every 50th patient on the adult age/sex register (ie, all those 16 years or over), was sent a questionnaire at home with a stamped addressed envelope for reply. This amounted to 220 questionnaires after those with known psychotic or dementing illnesses were excluded (five in total). One hundred and eleven questionnaires were returned, one of which was discounted because the patient was already a member of the surgery gorup and another because it was incorrectly completed. Two weeks were allowed for the return of the questionnaire. The results from the 109 correctly completed questionnaires were labelled 'home group'.

Results

The results were collected and tabulated (Tables 2 and 3). A chi-squared analysis was then performed upon the data. For the purpose of analysis the responses of the surgery and home group were compared on each item of the questionnaire.

Numerical data

As can be seen from Table 3 all topics for discussion were thought to be appropriate by some patients. 'Stress' was the most 'popular' with spiritual problems being less so.

As expected, women were over-represented in the surgery group. This was significantly so for women aged 25-40 years (surgery vs home group $\chi^2=8.538$, $P<0.05$). There were no significant differences between home and surgery groups or men and women on grounds of marital status.

Women as a group (surgery plus home) were more likely than men to be multiple attenders ($\chi^2=5.33$, $P<0.05$).

For the purpose of discussion those patients attending over five times in the previous year are termed 'multiple attenders' (see Table 4).

There was no significant difference between church attendance in surgery and home groups for either sex, but in women in the surgery group, church attendance was significantly more likely in multiple attenders ($\chi^2=5.3$, $P<0.05$).

Women and men in the surgery groups were significantly more likely than those of home groups to be multiple attenders (women χ^2 3.89, $P<0.05$; men χ^2 4.813; $P<0.05$).

Table 2. Demographic data of those returning study questionnaires

	Surgery group (n=133)		*Home group (n=109)*	
	Female (n=101)	*Male (n=32)*	*Female (n=64)*	*Male (n=45)*
Age				
Under 25 years	11	2	6	4
25-40 years	33	11	8	11
41-60 years	31	10	27	18
Over 60 years	26	9	23	12
Marital status				
Single	13	4	8	10
Married/living with partner	64	22	41	30
Divorced/separated	11	4	5	1
Widowed	13	2	10	4
GP attendances in last year				
0-1	10	5	18	22
1-5	48	16	28	17
Over 5	43	11	18	6
Church attenders	30	8	25	15

Table 3. Responses to questions 1 and 2

	Surgery group		*Home group*	
	Female (n=101)	*Male (n=32)*	*Female (n=64)*	*Male (n=45)*
Topics appropriate to discuss with GP				
Flu	75	28	57	33
Headaches	84	28	58	40
Stress	85	31	60	41
Giving up smoking	62	25	42	26
Housing problems	24	10	15	2
Marital problems	39	21	28	12
Sexual difficulties	70	27	49	36
Family/relationship difficulties	38	18	20	12
Spiritual problems	7	9	6	3
Use of alternative therapies	46	9	24	12
Hypnosis	14	1	2	2
Osteopathy	24	4	17	5
Acupuncture	8	4	2	5
Herbalism	12	2	4	2
Homeopathy	23	2	6	1
Reflexology	2	0	1	0
Healing	2	0	0	0
Psychoanalysis	0	0	0	1

Table 4. Multiple attenders, church attendance and use of alternative therapies

	Surgery group multiple attenders		*Home group multiple attenders*	
	Female	*Male*	*Female*	*Male*
Total	43	11	18	6
Using alternative therapies	22	2	8	2
Attending church	18	3	9	2

Turning to alternative therapies, women in the surgery group were significantly more likely than those in the home to have used homeopathy ($\chi^2=4.854$, $P<0.05$) and hypnosis ($X^2=5.157$, $P<0.05$). Women in both groups appear more likely than men to have used alternative therapy of some sort but the differences failed to reach significance (surgery group $\chi^2=3.04$, home group $\chi^2=3.44$). The use of alternative therapies was not a marker for multiple attendance.

In their responses to question 1, those topics that were suitable to discuss with their doctor, the four groups of patients (women/surgery, men/surgery, women/home, men/home) showed similar trends. Housing and marital problems, family/relationship difficulties and spiritual problems were the least likely to be discussed amongst all the groups. There were few significant differences except the following:

(1) women in the home group would discuss flu more than women in the surgery group ($\chi^2=5.367$, $P<0.05$)

(2) men in the surgery group were more likely than women in the surgery group to discuss marital problems with their doctor ($\chi^2=7.16$, $P<0.01$), and also more likely to do so than men in the home group ($\chi^2=11.59$, $P<0.01$).

(3) With regard to family/relationship difficulties, men in the surgery were more likely to discuss this than men in the home group ($\chi^2=6.882$, $P<0.01$)
(4) With regard to those considering spiritual problems suitable to discuss with their doctor the numbers were small, but men in the surgery group over-represented relative to women in the surgery group ($\chi^2=10.315$, $P<0.01$) and men in the home group ($\chi^2=6.546$, $P<0.01$). There was no relationship between church attendance and desire to discuss spiritual problems.

Qualitative data

In the course of the questionnaire patients were asked open questions relating to two areas: whether there were any topics they would not wish to discuss with their doctor, and whether there had ever been a question that they wished he or she had asked. Naturally these generated disparate data, some of the topics already having been alluded to in question 1. However, few patients (10 in total) noted areas which they would not wish to discuss with their doctor (sex, 4; spiritual problems, 3; money, 3).

Again relatively few outlined questions that they would like to have been asked but were not (21). There were no statistical trends but broadly categorized, these questions related to how they felt (feelings, 11; anything else, 3; more information, 2; the offer of a second opinion, 1; comments relating to 'time', 4).

Some of the statements have been included below.

'I wish my GP at the time had really asked me more about how I really felt about a hysterectomy' (female in home group).
'As a psoriasis sufferer, any interest in how I feel instead of what the doctor thinks I should feel would be welcome (female in home group).
'How do I really feel about my problem, ie trying to be lighthearted about something that is really worrying me which does not get expected response' (female in home group).
'If people spent less time waiting to see the doctor they may feel able to ask questions instead of feeling guilty about using other people's time' (male in surgery group).
'Not problems other than medical matters. Doctors have more than enough to do looking after medical problems' (female in surgery group).
'Heart to heart chats on general wellbeing and/or specific problems are difficult because the doctors concerned are always overstretched. One feels one shouldn't waste the doctors' time when there are many waiting to see him/her' (female in surgery group).
'It is difficult to bring up the subject of sexual difficulties spontaneously' (female in surgery group).
'If I have been very worried - query malignancy - I want to ask but am too worried to put the question into words. Also do not want to look neurotic' (female in surgery group).

Discussion

A questionnaire study of this sort can at best only offer a crude static appraisal of many dynamic processes - attitudes, attendance patterns, marital status and beliefs. Patients were left to their own devices so that the interpretation placed on certain questions may be open to debate and the definition of such categories as 'homeopathy' relies very much on the patient's understanding. Those adults with literacy difficulties would obviously be disadvantaged as would those with impaired memories. The study relies on subjective information and recall (eg attendances in the previous year). Nevertheless it is a descriptive study and the emphasis throughout was to discover patients' attitudes with minimal bias or influence from a doctor, hence the inclusion of qualitative data.

Patients' diagnoses or reasons for attendance were not included nor was employment data and the over-representation of women in the surgery group is to be expected and is a pitfall of the design of such studies[18]. Middle-aged women consult their doctors more frequently and are also more likely to have attended with children or elderly relatives. Also, no attempt was made to control for doctor-initiated attendances.

However, the protean nature of the consultation is reinforced. The questionnaire was designed to present increasingly abstract topics for discussion, to the point of spiritual problems, and even then over 10% of patients regarded this as appropriate. The sample size represents approximately 2% of the adult population of the practice, despite a 50% response rate to the questionnaire in the home group, and seems likely therefore to provide a meaningful insight into patients' views. There was relatively slight dissent in terms of the limits to topics the doctor could discuss. This is perhaps evidence for Illich's accusation of the medicalization of all areas of life[29]. It is particularly interesting that this should be more pronounced among male attenders than females. It serves to emphasize the 'differentness' of those attending (but may also be a statistical effect of small numbers).

Naturally multiple attenders were over-represented in the surgery group and it is notable in the light of Pietroni's comments above[16] that church attendance should be associated with multiple attendance at the GPs. The present study can only point to this association but there are many interpretations, casual, causal or otherwise which are equally tenable. Do the chronically sick attend church more than the 'well', or is there a greater analogy between doctor and priest than Balint's 'apostolic role' implies[30] or is there something in the attender which seeks both? The study does not address religious belief, merely attendance.

Women attending the surgery, though not necessarily multiple attenders, were significantly more likely to have used homeopathy at some point in the past. The numbers were large for all groups of women (23.8% attenders, 9.4 non-attenders) and emphasize the resort to alternative therapies seen amongst all groups (37.6% of all patients). Thus it would appear that taking a history of alternative therapies during the consultation would not be a wasted exercise especially since some therapies have a degree of efficacy confirmed scientifically[31-34], and some others such as herbal extracts are not without toxic side effects[35]. It would also provide an insight into the patient's view of illness and health, and the perspective they are searching for.

The qualitative data from the study highlights the open access the doctor is given to many areas of the patient's life and the invitation to spend time in the exploration of feelings.

Lastly, the findings should make us question what we are trying to achieve in the consultation and what it is our patients expect from us. This question could never be more topical.

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